STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING -- B. WING	10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUTSONWOOD AT BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 10/05/23 & 10/06/23 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 At this Emergency Preparedness survey, Hutsonwood at Brazil was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 105 certified beds and had a census of 67 at the time of this visit. Quality Review completed on 10/11/23	E 0000	ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130 Dear Ms. Buroker, On oct 6,2023 life safety survey (3RM421) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of oct 27,2023. Please feel free to call me with any further questions at 1 (812) 446-2636.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Manoj Berry	Executive Director	10/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Respectfully submitted, Manoj Berry (Executive Director) Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 10/05/23 & 10/06/23 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 At this Life Safety Code survey, Hutsonwood at Brazil was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 105 and had a census of 67 at the time of this survey.	K 0000	ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130 Dear Ms. Buroker, On oct 6,2023 life safety survey (3RM421) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance	

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	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached garage used as a maintenance shop and one small wood shed used for facility storage. Quality Review completed on 10/11/23		with the applicable requirements as of the date set forth in the Plan of Correction of oct 27,2023. Please feel free to call me with any further questions at 1 (812) 446-2636. Respectfully submitted, Manoj Berry (Executive Director) Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the			

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	safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.			

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	18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 5 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect at least 20 residents and staff on the back hall. Findings include: Based on observation with the Maintenance Director on 10/06/23 at 10:55 a.m., the exit door by resident room #218 was marked as a facility exit, magnetically locked, and could be opened by entering a four-digit code on the access control pad; but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit door was not posted by the access control pad. The finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0222	K-0222 Egress Doors The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: No resident was found to be affected by this alleged deficiency. Maintenance director posted the code immediately on Exit door next to room 218. 2) How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. No one was affected. 3) Measures put into place/ System changes: The Maintenance Director or Designee will conduct rounds once weekly and check all exit door have codes posted x 6 months. 4)How the corrective actions will be monitored: The Executive Director will review the Preventative Maintenance Worksheets monthly. The results	10/27/2023

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			of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance:10/27/2023.	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure all battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect staff at the generator. Findings include: Based on observations on 10/06/23 with the Maintenance Director during a tour of the facility at 11:12 a.m., the battery operated emergency light marked #6 on an exterior wall by the generator	K 0291	K-0291 Emergency Lighting The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified:	10/27/2023

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	failed to function when its respective test button was pushed five times. Based on interview at the time of the observation, the Maintenance Director stated battery operated lights in the facility are tested monthly and confirmed the aforementioned battery operated emergency light failed to function when its respective test button was pushed. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		No resident was found to be affected by this alleged deficiency. Battery operated emergency light 6 was replaced. 2) How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. No one was affected. 3) Measures put into place/ System changes: The Maintenance Director or Designee will conduct rounds one time weekly to check all battery-operated emergency lights are working x 6 months. 4)How the corrective actions will be monitored: The Executive Director will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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			5) Date of compliance:10/27/2023.	
K 0353 SS=D Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation, and interview; the facility failed to ensure all sprinkler heads showing signs of corrosion were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage;	K 0353	K-0353 Sprinkler system The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	10/27/2023

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	shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect staff in the Laundry rooms. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 10:45 a.m. on 10/06/23, the sprinkler located in the mechanical room inside the laundry rooms appeared green in color showing signs of corrosion. Based on interview at the time of observation, the Maintenance Director confirmed the automatic sprinkler was green and showed signs of corrosion. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: No resident was found to be affected by this alleged deficiency. The sprinkler head in the mechanical room inside the laundry room has been replaced. 2) How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. No one was affected. The Maintenance Director checked all sprinkler heads in the building to ensure they were free of leakage, corrosion, physical damage and loss of fluid. 3) Measures put into place/ System changes:	

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			The Maintenance Director or Designee will conduct rounds once weekly and check sprinkler heads are free of leakage, corrosion, physical damage and loss of fluid x 6 months. 4)How the corrective actions will be monitored: The Executive Director will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance:10/27/2023.	